



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR AHMED KHALIFA
1415 SOUTH HWY 6 SUITE 400D
SUGARLAND TX 77478

Respondent Name

TARGET CORP

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-0678-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am in receipt of the attached E.O.B. related to the date of service August 17, 2010. Based on this E.O.B. the medical bill of \$199.22 for the procedural code 297096-50 was reduced to \$169.34, the medical bill of \$13.33 for the procedural code 72200-26 was reduced to \$11.42 and the medical bill of \$43.71 for the procedural code 77003 was reduced to \$27.15. The rational for the reduction was 'Any network reduction is in accordance with network referenced –Focus/Beech Street.' "Please note that Dr. Ahmed Khalifa...never had a contract with Beech Street/Focus."

Amount in Dispute: \$38.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier reduced the provider's bill according to an informal network agreement through Focus/Beech Street." "The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Response Submitted by: Flahive, Ogden & Latson, P.O. Box 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 17, 2010	CPT Code 72200-26	\$2.00	\$2.00
	CPT Code 77003-26	\$6.56	\$6.56
	CPT Code 27096-50 (x2)	\$29.88	\$29.88
TOTAL		\$38.44	\$38.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 15, 2010

- 100-Any network reduction is in accordance with the network referenced above.
- 689-Reimbursement for this procedure code has been calculated according to the bilateral procedure rule.

Explanation of benefits dated September 17, 2010

- 45-Charges exceed your contracted/legislated fee arrangement.
- 100-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
- 59-Reimbursement for this procedure code has been calculated according to the bilateral procedure rule.
- 689-Processed based on multiple or concurrent procedure rules.(For example multiple surgery or diagnostic imaging, concurrent anesthesia.)...

Explanation of benefits dated October 11, 2010

- 664-Description not available.

Explanation of benefits dated October 15, 2010

- W4-No additional reimbursement allowed after review of appeal/reconsideration.
- 850-664-No additional reimbursement allowed after review of appeal/reconsideration. \$11.33
- 850-664-No additional reimbursement allowed after review of appeal/reconsideration. \$37.15
- 850-664-No additional reimbursement allowed after review of appeal/reconsideration. \$84.67

Issues

1. Was the reduction in payment based upon a contractual agreement supported?
2. Is the requestor entitled to additional reimbursement for CPT code 72200-26?
3. Is the requestor entitled to additional reimbursement for CPT code 77003-26?
4. Is the requestor entitled to additional reimbursement for CPT code 27096-50?

Findings

1. According to the explanation of benefits, the services in dispute were reduced pursuant to an informal network contract as described by §413.0115. Section §413.011(d-3) states that the division may request copies of each contract under which fee are being paid and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division. On October 24, 2011, the division requested a copy of the contract between the network and the health care provider, and documentation to support that the requestor was notified in accordance with 28 Texas Administrative Code §133.4. The carrier failed to provide a copy of the contract, nor did they provide proof that the requestor was notified. Consequently, the carrier is required to pay fees in accordance with 28 Texas Administrative Code §134.203 for the services in this dispute.
2. CPT code 72200-26 is defined as "Radiologic examination, sacroiliac joints; less than 3 views."

The requestor added modifier "26-Professional Component" to the code because "Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number."

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the

established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77027, which is located in Harris County.

The MAR for CPT code 72200-26 in Harris County is \$16.75 (WC Conv 68.19/Medicare Conversion 36.8729 X \$9.06 participating amount). CPT code 72200-26 is exempt from the multiple procedure rule discounting; therefore, a reduction to the MAR will not be taken. The respondent paid \$11.33. The difference between the MAR and amount paid is \$5.42. The requestor is seeking additional reimbursement of \$2.00; this amount is recommended.

3. CPT code 77003-26 is defined as "Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid).

The MAR for CPT code 77003-26 in Harris County is \$54.92 (WC Conv 68.19/Medicare Conversion 36.8729 X \$29.70 participating amount). CPT code 77003-26 is exempt from the multiple procedure rule discounting; therefore, a reduction to the MAR will not be taken. The respondent paid \$37.15. The difference between the MAR and amount paid is \$17.77. The requestor is seeking additional reimbursement of \$6.56; this amount is recommended.

4. CPT code 27096-50 is defined as "Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed."

The requestor added modifier "50-Bilateral Procedure.

The MAR for CPT code 27096-50 in Harris County is \$199.56 (WC Conv 68.19/Medicare Conversion 36.8729 X \$71.94 participating amount). The respondent paid \$169.34. The difference between the MAR and amount paid is \$30.22. The requestor is seeking additional reimbursement of \$29.88; this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$38.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$38.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

2/29/2012

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.